WOODHOLME
GASTROENTEROLOGY ASSOCIATES
A LifeBridge Health Partner

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PLEASE READ THE FORM CAREFULLY AND FILL OUT COMPLETELY

1. I AUTHORIZE:

Name of sending person/organization

Street Address

City State Zip Code

2. TO RELEASE TO:

Name of receiving person/organization

Street Address

City State Zip Code

3. INFORMATION TO BE RELEASED: (Check all applicable)
☐ All Progress Notes
☐ Lab Reports
☐ X-Ray Reports
☐ Other

Fax # _____

4. RECORDS FROM THE TIME PERIOD: _____ to _____

5. PURPOSE OR NEED FOR DISCLOSURE: (Check applicable purpose)
☐ Continued Medical Care
☐ Payment of Insurance Claim
☐ Legal
☐ Other

6. I understand that this authorization shall be valid for 90 Days. I understand that I may revoke this consent form at any time except to the extent that action has already been taken.

7. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

8. The requester may be provided with a copy of this authorization.

Patient's Name (at time of treatment)

Patient's Date of Birth

Street Address

Daytime Phone Number

City State Zip Code

Date

Signature of Patient

## ALLOW 7 -14 BUSINESS DAYS TO PROCESS REQUEST


1838 Greene Tree Road
Suite 400
Baltimore, MD 21208
Phone 410-602-7782
Fax 410-609-9963

802 Landmark Drive
Suite 129
Glen Burnie, MD 21061
Phone 410-863-4899
Fax 443-873-2454

295 Stoner Avenue
Suite 204
Westminster, MD 21157
Phone 410-876-8332
Fax 410-609-9963

21 Crossroads Drive
Suite 205
Owings Mills, MD 21117
Phone 410-356-2396
Fax 410-609-9963